EXHIBIT Y

IN THE UNITED STATES DISTRICT COURT

OF THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHARLESTON DIVISION

IN RE: ETHICON, INC., PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	Master File No. 2:12-MD-02327 MDL 2327
THIS DOCUMENT RELATES TO THE FOLLOWING CASES IN WAVE 1 OF MDL 200:	JOSEPH R. GOODWIN U.S. DISTRICT JUDGE
BETTY FUNDERBURKE Plaintiff, vs. ETHICON, INC., ET AL. Defendant.	Civil Action No. 2:12-cv-00957

--- This is the Deposition of VLADIMIR IAKOVLEV, MD, taken at the Hilton Hotel, 145 Richmond Street West, Toronto, Ontario, on the 4th day of March, 2016.

REPORTED BY: HELEN MARTINEAU

CERTIFIED SHORTHAND REPORTER

Donna Loustaunau)
v. Ethicon, Inc., et al.)
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Elizabeth Blynn Wolfe)
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Barbara Vignos-Ware, et al.)
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Dina Sanders Bennett)
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Charlene Logan Taylor)
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Cynthia Nix)
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Barbara Kaiser)
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Joan Adams)
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Dina Destefano-Raston, et al.)
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Cindy Smith)
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Virginia White, et al.)
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Dee McBrayer, et al.)
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Kathleen Wolfe)
v. Ethicon, Inc., et al.)
Civil Action No. 2:12-cv-00337)

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A P P E A R A N C E S: continued

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--- Upon commencing at 3:14 p.m.
(WHEREUPON, the witness was duly affirmed.)
VLADIMIR IAKOVLEV, MD,
called as a witness herein,
having been first duly affirmed,
was examined and testified as follows:
CROSS-EXAMINATION BY MR. COMBS:
Q. Dr. Iakovlev, I want to ask you some questions about your -- let's go off the record.
--- Off the record at 3:14 p.m.
--- Back on the record at 3:14 p.m.
BY MR. COMBS:
Q. Dr. Iakovlev, we took a break for a second and Mr. Thornburgh handed me your flash drive for this case and we've marked that as Funderburke Exhibit 3.
---EXHIBIT NO. 3: Flash drive containing files reviewed by Dr. Iakovlev in compiling his clinico-pathological report re. Betty Funderburke.
BY MR. COMBS:
Q. Is that the flash drive that you provided to counsel with your materials that your

relied on in this case?
A. Yes.
Q. I have not opened it up yet, but would it have the medical records and chain of custody form on it?
A. Yes.
Q. Would there be anything else on it?
A. No, there might be several chain of custody forms as there were several specimens.
Q. And if there was just one specimen in this case it would just be one chain of custody?
A. That's correct.
Q. And I took your deposition in an earlier case and I asked you if you could provide us with the bill for that case and you were not able to. Is Funderburke basically the same?
A. I have not produced any bills for any of the 35 plus patients.
Q. Alright. And if you'll bear with me and let me ask a long question maybe we can just short circuit some of this. Would it be a fair statement that in the Funderburke case that you have not kept track of the specific amount of

hours you worked on that case, nor the days or actual times that you worked on for that case but plan, at some point in the future, to issue a bill based upon your estimate of how much time you worked on the case?
MR. THORNBURGH: Objection.
THE DEPONENT: That's correct.
BY MR. COMBS:
Q. And would all the work in that case have taken place from whatever the first chain of custody form shows you received the specimen until the date the report was issued on February 1st?
A. That's correct. I just want to add that this estimation of time is my routine way of producing bills, or doing bills. I've been doing it for two years now for all other litigations and other patients, including Ethicon litigation.
Q. And can you give me a ballpark for the amount of time that you would have spent on the Funderburke case? In the earlier deposition you told me 15 to 20 hours. Would this be in that ballpark too?
A. Yes.
Q. Okay.

A. They all would be in that park. Again it will depend on the amount of the records and number of images, these are variables. To produce a report I need approximately the same amount of time, usually about 2 hours, but the images and the records are different.
Q. And so the actual writing of the report takes about two hours and the creation of the slides is what takes the additional time?
A. And review of medical records to produce a summary.
Q. Dr. Iakovlev, I've marked as Exhibit 1 a copy of the case specific report.
---EXHIBIT NO. 1: Clinico-pathological report of Dr. Vladimir Iakovlev re. Betty Funderburke.
BY MR. COMBS:
Q. And Exhibit 2 is the pathology report.
---EXHIBIT NO. 2: Pathology report for Betty Funderburke from the Duke Raleigh Hospital, Bates labeled FUNDERBURKEB_DURH_MDR00038.
MR. THORNBURGH: Do you have Exhibit 2

for me.
MR. COMBS: I think I just gave it to you.
MR. THORNBURGH: Here it is. Thank you.
BY MR. COMBS:
Q. Dr. Iakovlev, we've done this in some other cases. Basically I want to go through the slides and I want you to tell me what your trial testimony is going to be regarding the photographs in the report. So let's start with BF1a.
A. So how are we going to do it? I just describe or you will ask me questions?
Q. I think it would go faster if you just describe but I'll be glad to ask you some questions. I'll start.
Can you tell me from what point in Ms. Funderburke's body this sample came from?
MR. THORNBURGH: Objection.
THE DEPONENT: One point of time or anatomical location?
BY MR. COMBS:
Q. Anatomical collection.
A. Well anatomical location is not

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exactly point. This is a large structure so it's pretty bulky.
Q. So where did this come from?
A. Anterior vaginal wall.
Q. And is this a sample from the Prolift or the TVT?
A. Oh, that's Prolift.
Q. Now, when you received the sample in this case you just received one sample didn't you?
MR. THORNBURGH: Objection.
BY MR. COMBS:
Q. I'm looking at page four of your report.
A. I received H&E stains and stained slides of one specimen, that's correct.
Q. And you told us earlier that the specimen was a sample from the Prolift, is that correct?
A. Yes.
Q. You did not receive any samples from the TVT in this case did you?
A. From the pathological assessment I would say that it was unlikely part of TVT. I mean, this is based on pathological features so my

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impression was that all of the excised tissue, at least what I received, because -- let me see if it was totally submitted or not.
Q. I may have to ask you to repeat part of that answer because your voice trailed off.
A. I have to see what was submitted. See, what was submitted is only a part of this specimen. The part which was on the slide was consistent with Prolift device. So then no parts which I would definitely say TVT. However I don't know what was in the remaining nonsampled specimen.
Q. Understand. And you might be answering more than I thought I was asking in that question.
The photographs that you have depicted in your report would all be from the Prolift explant?
A. More likely than not.
Q. Okay. And as we sit here today there are not any of the photographs that you can point to that you would say come from the TVT?
A. Not with certainty.
Q. Now, in the legend for the slide

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BF1a you talk about the fact that the mesh was folded?
A. Yes.
Q. And you're not able to tell us whether that mesh was folded at the time of implantation are you?
MR. THORNBURGH: Objection.
THE DEPONENT: No. It folded sometime in the body. Exactly when it happened from the moment of when it was put in the body would be difficult to say.
BY MR. COMBS:
Q. And you don't plan on telling the jury the specific time at which this folding happened in this case do you?
MR. THORNBURGH: Objection.
THE DEPONENT: I can say that it happened sometime from the point it was put in the body to a number of months before it was explanted, because all these changes are at least months old so it couldn't happen right before the explantation.
BY MR. COMBS:
Q. It's possible that this folding

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occurred at the time it was implanted by the surgeon isn't it?
MR. THORNBURGH: Objection
THE DEPONENT: It's possible. It's possible that it was partially folded right away and then folding continued later on. I mean, there are many other scenarios and timing.
BY MR. COMBS:
Q. Alright. Let's see if we can short circuit some of this. Same question about the time that the folding occurred for BF1b, BF1c, BF2a, BF2b, BF2c, BF3. For all of those would your answer be the same that the folding could have happened at the time of implantation?
MR. THORNBURGH: Objection.
THE DEPONENT: Could have happened, but I believe it was -- the technique is to attempt to put it as flat as possible.
BY MR. COMBS:
Q. Dr. Iakovlev, on several of these slides, for example, BF1b and BF2b, there is a yellow line drawn. What do you plan to tell the jury that yellow line represents?
A. It represents the most likely plane

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of the mesh.
Q. Is that yellow line something that you added to this photograph?
A. Yes.
Q. And so that would be something with your computer program that you drew onto this picture?
A. Yes.
Q. And I just want to make sure it's clear that it's not something that you would see if you put the slide under the microscope?
A. Well, I mean, all slides have been like this for many cases. I mean, there is an unaltered copy and then there are copies with some markings and some of them have this yellow line depicting the most likely plane of the mesh, tracing of the mesh within the tissue.
Q. And just for example, the solid yellow lines on BF1b and BF2b those would be the lines that you placed on with the computer program while you were preparing the report?
A. That's correct.
Q. I want to ask you a question now about BF2c. What is it you plan to tell the jury

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about that slide at this trial?
A. It's folded mesh; it's incorporated by scar tissue; the most superficial layers are denser, the scar is much denser; in deeper portions of the mesh they have more fluid content, edema, so it's not as dense deeper down; and then the superficial portions are right under the mucosa, and then there's part of the mucosa.
So it just shows that the mesh is folded in the body. The scar tissue grows into the folds; it's incorporated like this in the body; it forms this multilayer, bulky irregular structure, together with the scar; and there is definite fluid misbalance within some parts of these folds. I mean, there's more fluid in some parts and less fluid in other parts.
Q. So if we're taking the photograph from top to bottom, the top, left-hand corner of the photograph that's what you're going to tell the jury was the mesh that was near the mucosa?
A. Yes.
Q. And then from kind of the middle third of that that's going to be what you term as the denser scar?

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A. Yes.
Q. And then the bottom third, right-hand corner of it that will be what you tell the jury is deeper and reflects more edema?
A. Yeah. More edematous scar. Scar which contains more fluid.
Q. And what's the criteria that you used to make the determination in Ms. Funderburke's case of the edema and the bottom third, right-hand portion?
A. Just density of the tissue, the spaces -- when there's fluid the components get separated further apart because fluid takes space in between.
Q. So are there any other factors other than the density of the tissue that you're relying on to draw that conclusion?
A. At that power you do not see, but if you go on higher power you can see that the capillaries are dilated. So the vessels they are more stagnant, they contain more fluid, they are larger, the outflow is slow from them. So it just goes together. You have more fluid in the vessels, it doesn't flow out the same rate as

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other places. And then the fluid slowly seeps into the tissue and stays in the tissue.
Q. So let me ask you now, what is it you're going to tell the jury about photograph BF3?
A. Just comparison between dense scar and more edematous, more fluid-rich scar tissue with some dilated vessels.
Q. And are the dilated vessels that you're referring to the ones that you have on the right-hand side that you're drawn little arrows to?
A. Some of them I've marked with the arrows.
Q. And in Ms. Funderburke's case will you be telling the jury of the cause of those dilated vessels?
A. Well, because it's a compartment, it's within the mesh fold so it's abnormal compartmentalization of the tissue. And clearly this is the only cause which interferes with the fluid's in and out flow.
Q. Is there anything else that you're going to tell the jury about BF3?

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A. Fluid misbalance can cause higher pressure within these compartments, and high pressure is associated with feeling of either itchiness which feels -- on the skin when it's edematous itchiness, or can go all the way to pain like in toothache. The pressure goes up so high in the compartment of the tooth and we feel pain.

Q. Are you going to be -- is there anything else about this slide, BF3, that you're going to tell the jury in this case?

A. No, that's it.

Q. What do you plan on telling the jury about the slide BF4?

A. This is the proximity of mesh to the mucosa. So if we -- so the reason for mesh exposure -- or one of the reasons for mesh excision at the time was mesh exposure. So this picture shows proximity of mesh to the mucosa. That image didn't capture exactly the erosion site but it's getting closer.

Q. Anything else that you plan on telling the jury about slide BF4?

MR. THORNBURGH: Objection.

THE DEPONENT: No.

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BY MR. COMBS:

Q. The photograph now that you've labeled BF5.

A. Yes.

Q. What do you plan to tell the jury about that?

A. Here is the erosion. You can see that mesh fibers are getting through the mucosa and there's inflammation. So clearly mucosa is disrupted. There is infection. There is inflammation.

Q. And what portion of Ms. Funderburke's vagina did this specimen come from?

A. Anterior wall.

Q. Can you be any more specific than that?

A. No.

Q. Can you tell us where on the anterior wall the erosion was?

MR. THORNBURGH: Objection.

THE DEPONENT: Somewhere in the anterior wall.

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BY MR. COMBS:

Q. Can you be any more specific?

A. I cannot.

Q. You made a comment about infection?

A. Yes.

Q. What was that comment?

A. Because there is inflammation around and there is exposure through the mucosa. So any open wound is invariably associated with infection and infection will trigger acute inflammation.

Q. Were any cultures taken of the site?

A. I'm a pathologist -- an anatomical pathologist so I determine if there is infection by observing acute inflammation. It has to go to the level to trigger acute inflammation. That's my tool to determine infection.

Q. So you determine infection based upon whether there is inflammation?

MR. THORNBURGH: Objection.

THE DEPONENT: Acute inflammation.

BY MR. COMBS:

Q. Were any cultures taken of the site?

A. I don't know.

Q. Was a diagnosis made by any

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physician that Ms. Funderburke suffered from a vaginal infection?

A. The diagnosis was made vaginal erosion, which comes together with infection.

Q. You cannot point me to any medical record for any of Ms. Funderburke's treating physicians diagnosed or as having a vaginal infection can you?

MR. THORNBURGH: Objection.

THE DEPONENT: I think we're looking for something artificial. It's not separated. Erosion is always associated with infection.

BY MR. COMBS:

Q. So I ask again, can you point me to any medical record where any treating physician diagnosed Ms. Funderburke as having an infection?

A. The way you word it no, because you're using legal lawyer's language and physicians use their own. Mesh erosion is -- everybody understands it's a given that there is infection there.

Q. And as we sit here today you cannot point us to any medical record or testimony from any physician that diagnosed Ms. Funderburke as

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having an infection can you?
MR. THORNBURGH: Objection.
THE DEPONENT: I was not looking for that because it is so obvious. I mean, one comes after another invariably so I wasn't even looking. Maybe it's there but I wouldn't pay attention because I mean this is obvious.
BY MR. COMBS:
Q. Okay. You can't point us to anything can you?
MR. THORNBURGH: Objection. Asked and answered. How many times are we going to do this?
THE DEPONENT: I cannot point because I wasn't paying attention to that specific. I wasn't expecting that question because that question is -- how I should say? I couldn't expect it possible.
BY MR. COMBS:
Q. Okay.
A. As a physician.
Q. Did you review the depositions of the treating physicians for Ms. Funderburke?
A. No.
Q. Were those provided to you?

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A. The depositions?
Q. Yes, sir.
A. I didn't ask for deposition.
Q. What is the diagnostic criteria that you use to diagnose a vaginal infection?
A. The diagnostic criteria to use infection in general is to observe acute inflammation. Assuming -- we use that in many other tissues. We get called for frozen section to determine the amount of neutrophils in some tissue to determine if there is infection. Because if some instance -- cultures take time. If you want to have an answer if there is infection or not you can do it by microscope, observing acute inflammation. That's what we do for knee implants and for other tissues and this is done within minutes. So I use the same criteria as I use for any other specimen. If there is acute inflammation, if there is infection.
Q. Was there any frank pus at the site of the erosion?
MR. THORNBURGH: Objection.
THE DEPONENT: That you would have to

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ask clinical -- treating physician if there was frank pus or little bit of oozing. I mean, I don't know. Frank pus is a lot of acute inflammation. This is a gross diagnosis of infection, frank pus. Under microscope I see parts of frank pus, neutrophils.
BY MR. COMBS:
Q. And you cannot point us to any pus in this photograph, can you?
MR. THORNBURGH: Objection.
THE DEPONENT: Well, I mean if I go to some areas this would qualify to fibrinopurulent exudant.
BY MR. COMBS:
Q. And did the treating pathologist who reviewed this specimen diagnose Ms. Funderburke as suffering from an infection?
MR. THORNBURGH: Objection.
THE DEPONENT: There is no comment on acute inflammation here.
BY MR. COMBS:
Q. And no finding by Dr. Draffin that Ms. Funderburke was suffering from an infection was there?

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A. Well it doesn't say either way if it wasn't or there was.
Q. And if she was suffering from an infection he would make that finding and comment on it wouldn't he?
MR. THORNBURGH: Objection.
THE DEPONENT: Not necessarily. Because he's concerned with malignancy, the describing and then -- see, "negative for malignancy".
BY MR. COMBS:
Q. Is it your testimony that Dr. Draffin was concerned about malignancy in Ms. Funderburke's explant that occurred on September 2010?
A. My testimony is all pathologists first are concerned with malignancies in any specimens. First we try to make sure that it's not malignant. If it's benign then most cases it doesn't even matter what you sign it out.
Pathology report is provided to clinicians to manage the patient immediately. So pathology report conveys information immediately.
Q. If Dr. Draffin had diagnosed an infection, that would have been indicated on the

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pathology report, wouldn't it?
MR. THORNBURGH: Objection.
THE DEPONENT: Not necessarily. He could just disregard some findings. I mean, you cannot put everything on this page. I don't know if he saw this or didn't. There's no comment. He doesn't say that there is no acute inflammation. If he said that then I would say, yes, he looked for it and he didn't see it. But this way I don't even know if he was looking for it or not.
BY MR. COMBS:
Q. No finding of acute inflammation is there?
MR. THORNBURGH: Objection.
THE DEPONENT: There was no way to determine if he was looking for it.
BY MR. COMBS:
Q. Is there any finding in Exhibit 2 that Ms. Funderburke suffered from acute inflammation?
A. No positive finding.
Q. Is there any finding in Exhibit 2 that Ms. Funderburke suffered from infection?
A. No positive finding, but also no

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negative finding.
Q. Is there anything else about the slide BF5 that you plan on telling the jury?
MR. THORNBURGH: Objection.
THE DEPONENT: No, nothing.
BY MR. COMBS:
Q. Okay. Anything else about the photograph in BF6 that you plan on telling the jury?
MR. THORNBURGH: Objection.
THE DEPONENT: Self-explanatory foreign body inflammation, that's it.
BY MR. COMBS:
Q. Anything else that you plan on telling the jury?
MR. THORNBURGH: Objection.
THE DEPONENT: There's some scarring around it. That's it.
BY MR. COMBS:
Q. Anything else?
A. No.
Q. The yellow that's drawn on the right-hand side that's something that you would have added in your computer program?

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A. Yes.
Q. And on the left-hand side the white spaces, what do those represent?
A. Mesh fibers. Some of them are still there, some of them are not.
Q. On the left-hand side the white circles, are the mesh fibers still within those white circles?
A. In some, in some are not.
Q. And which ones are the mesh fibers in?
A. It's hard to say. I would need polarizing lenses. Maybe all of them are still there. It's -- folded or not it's hard to say.
Q. Can you tell us as we sit here which ones of the white circles on the left-hand side contain mesh?
MR. THORNBURGH: Objection.
THE DEPONENT: I just told you I need polarizing lenses. This is the only way to say if there are fibers or not, when they're clear. When they're blue it's visible, but if it's not blue, if it's a clear fiber then it's invisible. I mean it's transparent in regular light.

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BY MR. COMBS:
Q. Do you know whether the mesh fibers would have been removed from the slide, that this is a photograph of, during the microtoming process?
A. It could have. I mean, some of them float away, some of them stay.
Q. Dr. Iakovlev, I want to ask you about the photographs of the slides that are at BF7 through 9.
A. Okay.
Q. And what is it that you're going to tell the jury about BF7?
A. Nerves, nerve branches can grow into the mesh, into the scar tissue.
Q. Anything else?
A. They become trapped within the scar tissue within the mesh. You can see small fibers. Clearly the tissue is innervated, can feel pain. That's it.
Q. What are you going to tell the jury about the photograph that's labeled BF8?
A. Now findings are similar to previous but there was chronic inflammation and the nerve branch and small nerve fibers around it are all

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within the area of inflammation, so it's just -- shows that inflamed tissue is innervated too.
Q. Anything else?
A. No.
Q. Same question about the photograph that's labeled BF9. What are you going to tell the jury about that?
A. Here is addition to previous findings that there is large dilated vessel and edematous trauma. So it just shows there is innervation within the edematous part of the scar tissue.
Q. Anything else?
A. No.
Q. I want to ask you for the photographs that are labeled BF7, BF8 and BF9 did you consult with a pathologist regarding Ms. Funderburke's case?
A. No. Why would I? I'm a certified licensed pathologist. I don't need neuropathologist to assess this.
Q. So the answer is, no, you didn't consult with a neuropathologist regarding Ms. Funderburke's case?

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MR. THORNBURGH: Objection.
THE DEPONENT: Neuropathologists examine brain, they examine large peripheral nerves for peripheral nerve diseases, they examine muscle biopsies. They don't examine meshes. I mean, this is completely out of their scope. They don't know about meshes anything. Why would I ask them?
BY MR. COMBS:
Q. Did you ask one regarding Ms. Funderburke's case?
MR. THORNBURGH: Objection. Asked and answered.
THE DEPONENT: How would -- why would I ask if they don't know what to look for?
BY MR. COMBS:
Q. Dr. Iakovlev, just yes or no?
MR. THORNBURGH: He's already answered that question.
BY MR. COMBS:
Q. Did you consult with a neuropathologist regarding Ms. Funderburke's case?
A. I wouldn't even think about it.
Q. So is the answer no?
A. The answer is no.

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MR. THORNBURGH: Which is the same answer he gave 20 lines ago.
MR. COMBS: Well then why did we spend all that time fighting about it?
MR. THORNBURGH: Because you kept on asking him.
MR. COMBS: Because it wasn't a clean answer.
MR. THORNBURGH: His answer was no.
BY MR. COMBS:
Q. Now, Dr. Iakovlev, did you do a count of nerve density regarding Ms. Funderburke's case?
A. If I had that synoptic data compiled I did. If I didn't -- if I don't have it then I didn't have time to do it.
Q. So we weren't provided a synoptic report in regard to Ms. Funderburke's case, does that mean that one was not prepared?
A. Most likely. When was it served?
Q. I assume February 1st.
A. Some of them were completed, some of them are not. It's irrelevant. I'm not doing nerve count to form my opinions. It's done for

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completely, for different purpose. Has nothing to do with the opinions -- well, it has something to do but I mean the exact nerve density doesn't help me either way in formulating my opinion. It's done for a different purpose.
Q. As we sit here today you're not aware of a synoptic report being prepared regarding Ms. Funderburke?
A. I don't know. I don't remember now.
Q. If we weren't provided one does it mean one wasn't done?
A. Most likely.
Q. Did you make any findings in Ms. Funderburke's case that any of the nerves were abnormal?
A. Abnormal in which way? Abnormal like disease or abnormal distorted?
Q. Let's start with disease. Did you make any findings that any of the nerves in Ms. Funderburke's case were diseased?
A. Well, from S100 it seems -- and from H&E I did not see any evidence of disease. There was no morphological evidence of disease. They looked more or less healthy nerves. They were in

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abnormal location. They were in scar within the mesh, that's what is abnormal. Some of them are very close to mesh fibers so some were probably distorted by the mesh to a degree. Again, that would be the only abnormality.

Q. And did you make any finding that nerves were distorted in Ms. Funderburke's case?

A. Well, I can see that this nerve is very close to the mesh fiber.

Q. And, Dr. Iakovlev, just so that the record's clear, what page are you on and which photograph?

A. Page 18, BF7.

Q. And which nerve are you referring to?

A. The one which is on the lower right. It's very close to the mesh fiber.

Q. Will you be testifying in this case that that nerve is distorted?

MR. THORNBURGH: Objection.

THE DEPONENT: Not significantly.

BY MR. COMBS:

Q. Are there any other nerves in Ms. Funderburke's sample that you consider to be

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distorted?

A. No.

MR. THORNBURGH: Objection. When you say nerves are you including branches and fibers and -- I mean, because there's a difference pathologically.

BY MR. COMBS:

Q. Alright.

A. If we're talking about little fibers, I mean, we can see that some fiber here is distorted but it's just a very thin fiber. If we're talking larger nerves and nerve branches which collect many fibers I don't see that degree of distortion in the slides, but I cannot rule it out because -- when it's so close. I don't know what's going on millimeter from here. If we cut deeper, deeper maybe that nerve is completely split by the fiber. I see it all the time, therefore the probability cannot be excluded because I've seen it so many times in so many specimens; the nerves get distorted by the fibers. But if you ask me if I have it in the pictures in my report the answer would be no.

Q. Will you be testifying in this case

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that Ms. Funderburke had any neuromas?

MR. THORNBURGH: Objection.

THE DEPONENT: No. My testimony would be that I did not see neuromas in the slides I examined, but however I cannot rule out that possibility.

BY MR. COMBS:

Q. No traumatic neuromas that you can point us to in any of these photographs, is that correct?

A. That's correct. In the photographs there are no traumatic neuromas.

Q. And no reference in the report to any findings of traumatic neuromas during your examination of the specimen?

A. I did not describe one.

Q. Dr. Iakovlev, I want to ask you about the nerve branches that you described in BF7, 8 and 9.

A. Yes.

Q. What nerve do those branches correspond to?

MR. THORNBURGH: Objection.

THE DEPONENT: I don't know. A

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myelinated nerve.

BY MR. COMBS:

Q. Do you know what nerve they stem to?

A. No.

Q. Do you know what nerve they communicate with?

MR. THORNBURGH: Objection.

THE DEPONENT: No.

BY MR. COMBS:

Q. Do you know whether these nerves are sensory nerves?

MR. THORNBURGH: Objection.

THE DEPONENT: I think we've been through this earlier. Most of the nerves in our body are mixed, sensory and motor. They contain different fibers. If we talk about fibers then the fibers can be either sensory or motor. When they come together in larger trunks they're all mixed. So once we have a larger nerve, by definition, it's mixed or over 90 percent of them are mixed.

BY MR. COMBS:

Q. The nerves you reference to in BF7, 8 and 9, those are not larger nerves, are they?

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MR. THORNBURGH: Objection.
BY MR. COMBS:
Q. I mean what you're describing is a larger nerve.
A. Let's get it clear. One fiber is like this. It's just one fiber so it delivers one function, either motor or sensory. Once you get two the likelihood one of them will be the other way around is higher, pretty much 50 percent. When you get a bunch the likelihood that at least one is sensory and/or one is motor is over 90 percent. So the larger the nerves get the more chances that they are mixed. It doesn't matter if they're somatic or autonomic. So that's -- larger nerves as they get larger there's more mixed function in them.
Q. Can you tell me whether any of the nerves that are depicted on BF7 are sensory nerves?
A. Let's put that term "sensory nerve" away, because sensory fibers, that would be more correct terminology, because fiber has only one function, either sensory or motor. When it's a nerve rarely they have only one function and

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usually it's sensory only. But most of -- over 90 percent of nerves would have mixed function, motor and sensory. So if we say sensory nerve or motor nerve you implying or you're limiting my answers only to that -- less than 10 percent nerves.
Q. So again my question is, can you tell me whether any of the nerves that you have labeled in BF7 are sensory nerves?
MR. THORNBURGH: Objection.
THE DEPONENT: So we going back. Are we talking about 90 percent, over 90 percent of the nerves in the human body or 10 percent of the human body. If you're separating them into motor and sensory then we're talking only a very small subset and limiting ourselves into pretty much nerve fibers. If you want to talk about nerves in general, over 90 percent, they are all mixed so we cannot use the term "sensory" or "motor".
I mean, again, once you get into smaller locations, into smaller, thin fibers getting close to skin most of them will be sensory, depends on location. Some of them will be only motor. Again, once it is larger it's mixed, once it's smaller the function may be narrower.

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BY MR. COMBS:
Q. I'll ask you can you point to any nerve branch on this photograph and tell me that that is a sensory fiber?
MR. THORNBURGH: Objection.
THE DEPONENT: Nerve or fiber?
BY MR. COMBS:
Q. We'll start with fiber. Can you tell me that anything on this photograph is a sensory fiber?
MR. THORNBURGH: Objection.
THE DEPONENT: It will be 50/50 split I guess if you go -- or depends on location. There will be probability that one fiber is motor and one is sensory. Once we get into nerves I can tell you more likely than not that these are mixed rather than what you're trying to say sensory only or motor only. So this is mixed. There's some motor function in it and some sensory. How much of it? What is the mix? I don't know.
BY MR. COMBS:
Q. Are there any receptors depicted on BF7?
MR. THORNBURGH: Objection.

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THE DEPONENT: Somewhere there but visible at high magnification, yes. You cannot see them at that level of magnification.
BY MR. COMBS:
Q. Are there any nerve receptors that are appreciable on BF7, BF8 or BF9?
MR. THORNBURGH: Objection.
THE DEPONENT: It's a low magnification. You cannot see them at that magnification. Did I imply that I can see them on that magnification?
BY MR. COMBS:
Q. What magnification would it have required for Ms. Funderburke's slide to have appreciated the receptors?
A. Pretty high. At least 40 or 60X and it would need a different stain. I'm not sure why we're talking about receptors. Receptors -- as a given, where there are nerves there are receptors because most nerves end with receptors. That's their targets.
Q. The strain that you performed was the S100, correct?
A. That's correct.
Q. You didn't perform any other type of

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staining in Ms. Funderburke's slides that would be specific to nerve receptors did you?
MR. THORNBURGH: Objection.
THE DEPONENT: It wasn't my intention. There is no purpose of it. You have nerves, you have receptors.
BY MR. COMBS:
Q. And for Ms. Funderburke's slides what stain would you have used if you were looking for receptors?
MR. THORNBURGH: Objection.
THE DEPONENT: It wasn't my intention and I was not going to do that because there is no purpose for that.
BY MR. COMBS:
Q. So my question is, if you had wanted to look for nerve receptors in Ms. Funderburke's sample, what stain would you use?
A. I did not. I did not want to and I will not do it. I don't see the purpose as a physician. Why are you forcing me to do something else? Are you teaching me how to do pathology?
Q. My question is if you had wanted to see nerve receptors what stain would you have

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used?
A. If I want to use -- repeat the question.
Q. If you had wanted to see nerve receptors in Ms. Funderburke's slides what stain would you have used?
MR. THORNBURGH: Objection.
THE DEPONENT: You can use PGP9.5, this is a stain, it's kind of a dirty old stain. It has been used in older studies. S100 can lead you to very end of the nerve fiber if it's myelinated. Neurofilament can give you a little bit better staining than PGP9.5 so it can show the endings of the bare fibers. You can do older stains like silver stain.
BY MR. COMBS:
Q. Ms. Funderburke's sample you did not do the PGP9.5 or the neurofilament stain did you?
MR. THORNBURGH: Objection.
THE DEPONENT: Didn't intend to and there was no purpose to do that.
BY MR. COMBS:
Q. You didn't do it?
A. Why are you trying to make it sound

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as if I could have and I should have but I didn't?
Q. That's your reading. My question is just did you do it?
A. No, I didn't.
Q. Okay.
A. Because I didn't need to.
Q. Okay.
A. Not because I wanted to hide something.
Q. Dr. Iakovlev, I want to ask you now about the slides BF -- basically BF10 through BF13b?
A. Okay.
Q. Are those all slides that you're going to use to tell the jury that you believe that was degradation in this case?
A. It's not I believe, I know it is, and your scientists also know that.
Q. So let's start with BF10. What is it you're going to tell the jury about BF10?
A. There is degradation bark observed in 2015, or '16, the same way that it was observed in 1983 by Ethicon scientists.
Q. Anything else?

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A. No. It's the same 30 years after.
Q. BF11a what is it you're going to tell the jury about that?
A. Same thing. There are blue fibers -- blue granules seen in the detached fragments of the bark exactly the same way as it was observed 30 years ago.
Q. Anything else?
A. These pictures they just show the birefringence of these fragments is independent from the core because they're separated, and the blue granules in the detached fragments are independent from the core. They are truly in the bark, the same way as it was described in Ethicon studies in 1980's.
And BF10 -- 11b, sorry, shows higher magnification and clearly you can see that the detached bark contains these blue granules. They were inserted specifically to identify polypropylene in the body. And it works grossly for surgeons to remove the mesh or see it in the bladder, as well microscopically. You see blue granules it means polypropylene.
Q. Anything else you're going to tell

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the jury about that slide?
A. No.
Q. What are you going to tell the jury about BF12?
A. Oh these colors are off, the printing is. The same thing, it's degraded, there is bark, there are blue granules in it but it's not a good picture.
Q. Anything else?
A. No.
Q. BF13a and 13b, what are you going to tell the jury about those?
A. Just repetition of other. Separated fragments of the bark with blue granules.
Q. Anything else?
A. No. It degraded, it cracked, there's -- it's brittle cracking.
Q. Anything else?
A. No. And then BF13b it's in polarized light, the same fragment. Now I can see the behavior of polypropylene in polarized light.
Q. Anything else?
A. No.
Q. Dr. Iakovlev, did you make a

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measurement of the thickness of what you term as the degradation layer on BF10?
A. No.
Q. For any of the paragraphs from BF10 through BF13b did you make a measurement of what you term as the degradation layer?
A. As I mentioned to you earlier, I don't need to measure it to determine that it's degraded. So I take measurements later on when I compile the synoptic notes.
Q. And since you didn't do a synoptic report in this case you didn't measure the layer?
A. No.
Q. Can you estimate for me how many microns thick it would be?
MR. THORNBURGH: Objection.
THE DEPONENT: It would be more of a visual memory because I've seen so many of them. Roughly 3 microns, 3.5.
BY MR. COMBS:
Q. And what would be the clinical impact to Ms. Funderburke from this 3.5 micron thick layer that you claim is --
MR. THORNBURGH: Objection.

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THE DEPONENT: It's not just 3.5 thick, it covers the entire mesh. So the entire mesh -- the whole interaction between the mesh and the body is through the degraded layer. So pretty much the body doesn't see anything but the degraded polypropylene. Whatever is deeper under the bark doesn't matter because it's not getting exposed to the tissue. And the surface area is much larger.
Now, in terms of clinical implications, we know that it's brittle and I observed its brittle behavior in microscopy, so it's not flexible as nondegraded part. It contributes to stiffening of the mesh. And the cracking also can harbor bacteria, which had been a problem in multifilament mesh, which is published in multiple papers.
And since it's degrading, as I said, where there's fire there's smoke. So if it's degrading it's producing fragments. I mean, degradation is decay or fragmentation of polymer so there are some molecules released. I don't know the components of this and what exactly the molecules. There's whole array of chemical

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molecules or chemical substances produced during degradation of polypropylene outside of the body because it's easy to measure. Some combination of those is produced in the body as well.
Q. You never saw Ms. Funderburke's mesh in vivo did you?
A. No.
Q. And you would not have been present in the operating room at the time this sample was explanted would you?
A. No.
Q. And have you spoken to any of Ms. Funderburke's treating physicians about this?
A. No.
Q. Have you read the deposition testimony from any of Ms. Funderburke's treating physicians about whether they believe the mesh degraded?
MR. THORNBURGH: Objection.
THE DEPONENT: No.
BY MR. COMBS:
Q. You played no role in preparing this specimen did you?
MR. THORNBURGH: Objection.

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THE DEPONENT: You mean before the slides were cut?
BY MR. COMBS:
Q. Yes, sir.
A. No.
Q. Do you know what the protocol was for the specimen preparation at Duke Hospital?
A. Well, judging by the quality of the histology it was within acceptable range. I did not see any evidence of mishandling. There is crisp histology. There is no reason to believe that it was outside of the standards.
Q. And following the explant of this mesh it would have been dehydrated wouldn't it?
A. It would be dehydrated, it would be put in xylene and then in paraffin and then cut and then rehydrated, stained and cover slipped.
Q. And treated with formalin?
A. Formalin was before. Dehydrated after.
Q. Anything else?
A. Labeled, shipped through FedEx to me.
Q. Do you know whether Dr. Visco used

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cauterization to remove this tissue sample?
A. Sometimes you can see it at the edges. Usually it's within half a millimeter or so the edges are burned. This edge has some -- it may be dry it may be cautering. I don't know. Sometimes I see actually the cautering melts bark and the core at the same time, just giving extra evidence that the bark is present while the excision surgery takes place.
In this case I cannot tell you if there's cautery artifact or definitive artifact at the edges. But in any case it's only the edges. I mean, the central part -- I mean, it's really hard to burn tissue to that degree, to burn that piece of tissue. It's really sizeable chunk of actual folded mesh here.
Q. Just a second ago you talked about the mesh being brittle. In Ms. Funderburke's case how did you make the determination that this mesh was brittle?
A. By appearance, indicating change in physical properties. Because how do you determine that the glass is brittle? When you break it, it breaks into pieces. How do you determine that

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plastic bag is not brittle? Because it doesn't break into pieces.
Q. Sorry, I interrupted you.
A. You can see that the glass is brittle when it's broken, not even touching it. The same way here, I see that it cracks, then it's not flexible.
Q. And prior to you seeing the mesh in this case it was microtomed wasn't it?
A. Yes, both the core and the bark. The core didn't crack but the bark was cracked.
MR. COMBS: Let's take a break.
--- Break taken at 4:11 p.m.
--- Upon resuming at 4:21 p.m.
BY MR. COMBS:
Q. Dr. Iakovlev, I had a question about the records that are all in the thumb drive versus the records that are listed in the expert report. And based on -- again, this is just a quick determination because I just received the thumb drive at the beginning of the deposition, but it looked like not all of the records that are in the report are also contained on the thumb drive. Which would control?

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A. So I explained it to Mr. Snowden for the previous case. The way the files are named and they are assembled is very confusing. So to me sometimes I don't know how to name or what to list in this. I do my best to list all providing institutions and all providing physicians, but sometimes I just don't know how to classify it or I cannot figure out what exactly it's coming from. So the best way to determine if I had the record and I reviewed it is to go to the thumb drive and see if it's there. Somewhere it might be buried somewhere in the complex. So that's why it might be apparent discrepancy but it's not, it's just the way the records are assembled.
Q. That's fine. That tells me everything I need to know. If it was a record you reviewed it's on the flash drive?
A. It may not be reflected and fall into one of the categories for several reasons, and most of them are not controlled by me.
Q. That's fine. You've answered the question I had.
Now I want to ask you a couple of questions about the sample that you had for

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Ms. Funderburke's mesh. No analytical testing was performed on that sample was it?
A. No.
MR. THORNBURGH: Objection.
BY MR. COMBS:
Q. You didn't ask anyone else to perform any analytical testing did you?
A. No.
Q. No other types of testing performed on the mesh, was there?
MR. THORNBURGH: Objection.
THE DEPONENT: Except for microscopy?
BY MR. COMBS:
Q. Yes, sir.
A. No.
Q. That would be the basis for your conclusions regarding, for example, degradation in this case would be based on your observation of the mesh through the light microscopy?
MR. THORNBURGH: Objection.
THE DEPONENT: Yes. As I think your scientists did 30 years ago.
BY MR. COMBS:
Q. No scanning? For example, no SEM.

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A. No.
Q. Now, Ms. Funderburke had a revision on March 31st, 2009, you did not review any sample from that revision did you?
A. Which day is it?
Q. March 31st, 2009.
A. I did not see any pathology so I don't know if there was any mesh submitted for pathology, and I did not have a specimen either.
Q. And same question regarding a revision procedure done on January 14, 2010, you didn't have any pathology from that either did you?
A. Yeah, from what I could determine in the records I did not see pathology report and I did not have specimen either.
Q. In this case you are not going to testify that you observed any obliterated arteries in Ms. Funderburke's sample are you?
MR. THORNBURGH: Objection. To the extent, Phil, we've asked for you to return your expert's slides and so he'll have an opportunity to look at that information and he's reserved the right in his report to supplement based on new

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information, including information contained in the slides that your expert will return or provide.
THE DEPONENT: And this will be pertinent to all findings. This is limited to what I had and I had only half. Your experts have the whole specimen.
BY MR. COMBS:
Q. In the slides and photographs that you reviewed in this case you did not see any obliterated arteries from Ms. Funderburke did you?
A. No.
Q. There were no slides or photographs that you're going to rely on to say that there were particles that had separated from the mesh in this case?
MR. THORNBURGH: Objection.
THE DEPONENT: Not to the size of being visible and not in this case.
BY MR. COMBS:
Q. Dr. Iakovlev, I want to ask you about the clinico-pathological correlation and on my copy of the report it's page 5.
A. Yes.

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Q. We'll go to the erosion section and let's talk about the first two sentences. And I don't want to retread this but for the purpose of this case I want to make sure the record's clear.
So the first two sentences of that section you say, "Mesh erosion is a complication unique from mesh surgeries. It cannot occur with nonmesh procedures." Isn't that at some point just a truism? I mean, you can't have a mesh erosion if no mesh was placed could you?
A. This is obvious. I don't know how to answer.
Q. Now, we discussed in a different deposition in an earlier case that you can have erosion from other foreign bodies that are implanted in the human body can't you?
MR. THORNBURGH: Phil, that's a general question now. I've asked you on another case. We're not here about the other case, we're here about the case specifics of this case.
BY MR. COMBS:
Q. Okay. Let's talk about Ms. Funderburke. If Ms. Funderburke had been implanted with pessary can you tell us whether

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that would or would not erode?
A. Pessaries are not implanted.
Q. Placed.
A. If we talk about if there was another foreign body implanted it could have eroded. That would be my answer. Pessaries are not implanted, at least not a normal use or intended use.
Q. And obviously I'm not a doctor. If I use the wrong term I'm sorry. In fact I think you corrected me about it once before already. So the question just is, if a pessary had been placed in Ms. Funderburke's vagina that could erode, couldn't it?
MR. THORNBURGH: Objection.
THE DEPONENT: Let's leave pessary alone because it's a really bad example. If there was another foreign body under the mucosa it could have eroded. That would be my answer.
BY MR. COMBS:
Q. I want to ask you about the clinico-pathological correlation that you did for Ms. Funderburke. You've never treated Ms. Funderburke have you?

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A. That's correct.
Q. Never examined her?
A. That's correct.
MR. THORNBURGH: Objection. Do you mean beyond the pathology?
THE DEPONENT: I examined her specimen but I have not examined her as a person.
BY MR. COMBS:
Q. You've never talked to her?
A. That's correct.
Q. You've never talked to her treating physicians?
A. That's correct.
Q. I think I asked you this but in case I forgot, you have not reviewed their depositions in this case?
A. That's correct.
Q. You do not have a doctor-patient relationship with Ms. Funderburke?
MR. THORNBURGH: Objection.
THE DEPONENT: Well, to a degree. I examined her specimen so this is my relationship with her, examination of her specimen.

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BY MR. COMBS:
Q. And that was part of the forensic process?
A. Medical-legal process. Forensics is somewhat different.
Q. You've never talked to any of Ms. Funderburke's family members have you?
A. That's correct.
Q. Earlier I asked you some questions about whether infection was listed in Exhibit 2, the pathology report.
A. Yes.
Q. There's no mention made of pain in Dr. Draffin's pathology report is there?
MR. THORNBURGH: Objection.
THE DEPONENT: Pain is a clinical symptom. It's elicited by taking history by clinical physicians. Pain is not part of pathological diagnosis, it has never been.
BY MR. COMBS:
Q. And there is no mention of contribution to urinary symptoms in Dr. Draffin's pathology report is there?
MR. THORNBURGH: Objection.

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THE DEPONENT: Again, this would be more of a clinico-pathological correlation. Correlation between pathology and clinical picture. Pathology reports just describe pathological findings. It doesn't do -- it doesn't extend to correlation between clinical symptoms and pathology.
BY MR. COMBS:
Q. And no finding by Dr. Draffin that there had been any degradation of Ms. Funderburke's implant?
A. There is -- no either way. He didn't examine -- he did not examine polypropylene mesh for degradation.
Q. Did he review it under a light microscope?
A. Yes, he did.
Q. That's what you did in this case as well, wasn't it? Review it under a light microscope?
A. That's correct.
Q. Dr. Draffin makes no finding that there was degradation of this implant does he?
A. He did not examine for it. Either

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way he is not describing degradation if it's there or it's not.
Q. And you've never talked to Dr. Draffin have you?
A. No.
Q. Do you have any basis for your testimony that Dr. Draffin did not examine for degradation?
A. Well, one part of this is there is no mentioning of degradation either way. If it's there or it's not. There's no description that he was examining.
Regular pathologists don't even know that polypropylene can degrade. I wouldn't expect them to know. So there are multiple reasons to believe that he didn't examine. I mean there are more reasons to believe he did not than he did.
Q. Do you know anything at all about Dr. Draffin's background or qualifications?
A. No, I don't.
Q. Have you ever had any professional interaction with him of any kind?
A. No.
Q. Dr. Iakovlev, I want to ask you a

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question about your statement on page 6. That, "The clinical records indicate an appearance of urge incontinence and frequent UTI after implantation of the Gynecare mesh devices." Do you see that?
A. Yes, I do.
Q. What records are you relying on that Ms. Funderburke had frequent UTIs after implantation of the mesh device?
A. So July 2nd, 2010, Duke Medicine, Dr. Visco:
"She does however endorse frequent urinary tract infections since her mesh placement and has been on Macrobid suppression for this essentially since her surgery."
Q. Is there any other records or references in the medical file that you are relying on for the basis of that statement?
A. Don't remember now. This is clearly stated in this record.
Q. Did Ms. Funderburke have UTIs prior to mesh implant?
A. I believe she had some.

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Q. And how many UTIs did Ms. Funderburke have after she had the implant?
A. Oh, now we're going into really clinical questions. It's beyond my scope. As I said, I just read what was written in the clinical notes. You're asking something which I wouldn't specifically get details.
Q. Are you going to offer an opinion at the trial of this case that Ms. Funderburke suffered increased urinary tract infections as a result of the placement of the mesh device, or are you going to leave that to somebody else?
A. Well, see, the description of UTIs is in the clinical records so it's not my opinion either way. I can see it's written there. So my job as a pathologist is to take this information and correlate with the pathology. So if you're asking me if she had or she had not it's not my opinion. I'm just copying whatever was in the record.
Q. Are you going to testify at trial that Ms. Funderburke had any urinary tract infection as a result of having the mesh implant?
MR. THORNBURGH: Objection.

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THE DEPONENT: So as my clinico-pathological correlation states that:
"Clinical records indicated change of pattern of urinary tract infections, frequent, to the degree that she required antibiotics continuously after the surgery."
So this is clinical records. And then I can show how this contributed through the mesh using my pathological assessment. Does that answer your question?
BY MR. COMBS:
Q. No.
MR. THORNBURGH: I think it actually absolutely answers your question. Are you going to offer these opinions? And he told you exactly the opinions that he's going to offer and the basis for those opinions.
BY MR. COMBS:
Q. Do you know the frequency of urinary tract infections that Ms. Funderburke had prior to the mesh implant?
MR. THORNBURGH: Objection.
THE DEPONENT: I don't. I mean I see

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what is written there that she has continuous antidiuretic suppression since her surgery. That's what I extract. Exact frequency, I mean, I think we are going beyond my scope. I'm not a clinician who is doing differential diagnosis through the records comparing pre- and post-. My role is not that.

My role is just to see what is in the records, already summarized, the decision to excise the mesh. And then I examine the mesh and I explain what pathological changes were in the clinical picture. How they were causing the clinical picture.

I'm not doing the clinical differential diagnosis so why are you asking me something I wouldn't look for? I wouldn't look for specific differences before and after. If it's there, if it's stated I see it, but trying to extract it myself it wouldn't be my role.

BY MR. COMBS:

Q. Has Ms. Funderburke had any urinary tract infections since the explant by Dr. Visco?

MR. THORNBURGH: Which explant? I'm sorry? Oh, by Dr. Visco.

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THE DEPONENT: I don't know. She could have some urinary tract infection. Let me see what was provided in the records.

MR. THORNBURGH: Are you talking about the July 2nd?

THE DEPONENT: She had several excisions and we are talking about --

BY MR. COMBS:

Q. I'm talking about the September 23rd, 2010 explant. So my question is has Ms. Funderburke had urinary tract infections since that explant?

A. I don't know. It wouldn't be my purpose again. So it's damaged already. There is TVT still there. It's not in my summary. I don't know if it was in the records. Again, there are several reasons I wouldn't necessarily focus on that.

Q. Do you know whether Ms. Funderburke has suffered from incontinence after the explant by Dr. Visco in September of 2010?

MR. THORNBURGH: Objection. Which? Any type?

THE DEPONENT: I don't know. Again I

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wouldn't focus specifically on that issue.

BY MR. COMBS:

Q. In your clinico-pathological correlation for Ms. Funderburke in relation to urinary symptoms, what you set forth at pages 6 and 7, is it important to you whether Ms. Funderburke has had incontinence or UTIs following the explant of the mesh?

A. Explant?

MR. THORNBURGH: Objection.

BY MR. COMBS:

Q. Yes.

A. Explant is not that important because you already have the damage. There is more of a -- more value in the changes after the implant. Explantation only part of it. Part of the mesh is still there. There is scarring, there is damage already. So I wouldn't expect it to be drastically different, it can in some cases. Again, I'm not a treating physician but to me I'm more focused on the change of pattern after implantation for the reasons I just described.

Q. So what urinary symptoms are you going to tell the jury that Ms. Funderburke

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suffered after placement of the Gynecare device?

MR. THORNBURGH: Objection.

THE DEPONENT: Well it's stated in my report. "Clinical records indicate an appearance of urge incontinence and frequent UTIs after implantation of Gynecare mesh devices." That's what I saw in the records.

BY MR. COMBS:

Q. And in order to make that determination that she suffered frequent UTIs after implantation, did you think it was necessary to know whether she had suffered frequent UTIs prior to implantation?

MR. THORNBURGH: Objection.

THE DEPONENT: I did not make a determination. I copied what was in the clinical records. Again, going into this again I'm not a urogynecologist or a urologist to make clinical determinations. I saw it in the record exactly as I read like 15 minutes ago.

BY MR. COMBS:

Q. You won't be testifying at the trial of this case that the mesh implant caused Ms. Funderburke to have frequent UTIs, will you?

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MR. THORNBURGH: Objection.
THE DEPONENT: Again, I can read it from the record. It's stated there. I saw it. I copied it and then I correlate it with the pathology. That's the extent I can testify.
BY MR. COMBS:
Q. Alright. And you have made no comparison of the frequency prior to the implant, while the implant was in place or after the implant had been explanted, have you?
MR. THORNBURGH: Objection. Asked and answered.
THE DEPONENT: I answered this question several times.
BY MR. COMBS:
Q. And is the answer no?
A. No, the answer is as I answered.
Q. If the answer is as you answered then tell me how many UTIs did Ms. Funderburke have prior to the implant?
A. Your previous question was what I'm going to testify regarding urinary symptoms. Now you're asking how many again.
Q. Okay. First sentence under your

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urinary symptoms you say, "Clinical records indicate an appearance of urge incontinent and frequent UTIs after implantation." If your testimony is going to be that she developed frequent UTIs after implantation I want to know what your knowledge is regarding UTIs prior to implantation.
A. Should I read that sentence again?
MR. THORNBURGH: One last time.
THE DEPONENT: One last time, yes.
MR. THORNBURGH: No more after this.
BY MR. COMBS:
Q. I understand the sentence. I'm asking before that. I'm asking before the implant. That's what I'm asking.
MR. THORNBURGH: Objection. He's already told you what he's going to do. What he does is he correlates what's said in the records to the pathology.
MR. COMBS: Dan, c'mon. Let's not have a speaking objection.
MR. THORNBURGH: This is not my -- it's not a speaking objection when he's already testified to that five times.

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MR. COMBS: That's a speaking objection.
BY MR. COMBS:
Q. Dr. Iakovlev, you know, I think it's an easy question. Do you know? Do you know whether Ms. Funderburke had frequent UTIs pre-implant?
A. What do you mean frequent? How many? She might have had 20, 30, since her birth. People have UTIs. This is all questions which are so vague and ambiguous and that's not what I do. I do go through the records and if I see something clearly stated I take it as face value what's in the records.
Q. Well, the question you're complaining about being vague because it uses the term "frequent" I'm using the term you used. Under "urinary" symptoms" that's what you say. So here's my question, did she have frequent UTIs pre-implant? Whatever criteria you're using to say that she had them after implant.
MR. THORNBURGH: Objection.
THE DEPONENT: So whatever you call frequent, not frequent, I clearly saw indication that the pattern of UTI changed. If she had them

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before whatever frequency the clinicians put in the record that frequent UTIs requiring antibiotic suppression since her surgery. That's how I see it. That's how it is in the records. We can pull the record itself not just my summary.
How many of them? I don't know. We can ask a clinician who put that sentence in.
BY MR. COMBS:
Q. Okay. Let's take a break for a couple of minutes.
--- Break taken at 4:49 p.m.
--- Upon resuming at 4:56 p.m.
BY MR. COMBS:
Q. Dr. Iakovlev, will you testify at the trial of this case that there were changes in Ms. Funderburke's tissue as a result of the mesh implant?
A. Yes.
Q. And have you seen any other pathology samples of Ms. Funderburke's tissue other than the one taken on September 23rd, 2010?
A. No.
Q. Haven't seen any before that have you?

A. No.
Q. Haven't seen any after that have you?
A. No.
Q. There's a section in your report regarding pain at page 6. What's your testimony going to be at the trial of this case regarding the location of Ms. Funderburke's pain?
A. Again, my testimony will not be making clinical assessments. I mean, I can only copy what is in the records.
Q. You don't know what the location of Ms. Funderburke's pain was, do you?
A. Well, I can go back into record and see where it was described. I myself did not elicit that history where the pain is. I did not examine.
Q. So any testimony that you had on that would just be based on what you read in the medical records?
A. That's correct.
Q. Do you know whether Ms. Funderburke suffered from dyspareunia or not?
A. It wasn't a separate section. So

from what I see dyspareunia wasn't the main complication which was evident in the records. If she had sex or sexual relationships I don't know. She certainly was at risk for dyspareunia if she had it or not, that would be a clinical question.
Q. And I started to interrupt you. Were you finish with your answer?
A. Yes.
Q. You do not know whether Mr. Funderburke was sexually active?
A. I don't.
Q. Ms. Funderburke suffered an erosion less than three months after her implant didn't she?
A. Sometime short of three months. She had an excision in three months.
Q. Was that as a result of a wound healing issue?
MR. THORNBURGH: Objection.
THE DEPONENT: A wound healing issue would be if somebody observes the wound and sees it doesn't heal, doesn't heal, doesn't heal and stays open. So there would be a continuous observation of this. If there's a gap in it then

you don't know, if it healed and then became eroded. So -- but in any case if there is wound healing issue the object which prevented it from healing, would be mesh.
BY MR. COMBS:
Q. You do not know whether Ms. Funderburke suffered from a wound healing issue in relation to her December 31st, 2008 implant do you?
MR. THORNBURGH: Objection.
THE DEPONENT: Well definitely, once it became exposed the wound cannot heal. The foreign body prevents it from healing.
BY MR. COMBS:
Q. Do you know when her exposure first manifested?
A. Well, the record, as you said sometime within the first three months after implantation.
Q. And Ms. Funderburke is a diabetic isn't she?
A. Yes, she is.
Q. As a result of Ms. Funderburke being a diabetic is she likely to have poorer wound

healing?
MR. THORNBURGH: Objection.
THE DEPONENT: Well, see there are many diabetic patients without the mesh and they don't develop mesh erosion or poor healing around the mesh. And at the same time, many diabetics heal over this. There would be some changes. It depends on the patient. I don't personally know or I'm not aware that diabetes is a contraindication for mesh surgery. Diabetes could have contributed to delayed wound healing. But again, if there was no mesh there wouldn't be a wound to begin with.
BY MR. COMBS:
Q. All surgeries are accompanied by wounds, aren't they?
A. Yes, but not all contain foreign bodies.
Q. You do not know how Ms. Funderburke's mesh was placed, do you?
MR. THORNBURGH: Objection.
THE DEPONENT: What do you mean how?
BY MR. COMBS:
Q. Well, whether it was placed properly

or not during the surgery.

A. No, I don't know specific details. This would be a clinical question.

Q. Dr. Iakovlev, I don't have any other questions related to Ms. Funderburke.

MR. THORNBURGH: I may, just give me one second. No questions. Thank you.

--- Whereupon the examination was completed at 5:04 p.m.

REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and accurate transcript of my shorthand notes so taken.

_____

PER: HELEN MARTINEAU
CERTIFIED SHORTHAND REPORTER.

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ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

VLADIMIR IAKOVLEV, MD DATE

Subscribed and sworn to before me this _____ day of _____, 20____.

My commission expires:_____

_____

Notary Public

LAWYER'S NOTES

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